New Client Paperwork

14115 Lovers Lane
Culpeper, VA 22701
Phone: 540-225-1150
Fax: 540-595-3482
CSTARs4therapy@gmail.com

Date: __________________ Person Completing this Form: _____________________________________

Client/Child's Name: ____ ☐Male ☐Female

Date of Birth (DOB): ________________ Child's Preferred Name: ☐Same or ______________________

Address: ____

Other children in the home? ☐NONE or Names/ages: ____

Languages other than English used at home? ☐NONE or ____

Legal Guardian: ☐Parents ☐Mother ☐Father ☐Other: ____

Mother's Name: ____ DOB: __________________

Address: ☐Same or ____

Home Phone #: ____________________ Cell #: ______________________ OK to text? Yes

Work Phone #: _____________________ Employer/Occupation: _______________________________________

Preferred phone: ☐Home ☐Cell ☐Work Email address: ____

Father's Name: ____ DOB: __________________

Address: ☐Same or ____

Home Phone #: ____________________ Cell #: ______________________ OK to text? Yes

Work Phone #: _____________________ Employer/Occupation: _______________________________________

Preferred phone: ☐Home ☐Cell ☐Work Email address: ____

Referring physician: ________________________________ Practice Name: ____________________________

Address: ____

Phone #: ___________________________ Fax # (to send reports to physician): _______________________

Primary Care Physician: ☐ Same as referring OR Name: ____

Address: ____

Phone #: ___________________________ Fax # (to send reports to physician): _______________________

Last check-up date: _____________ Height: _____________ Weight: _____________ Concerns: Yes

If yes, describe: ____

Child's immunizations up to date? Yes If no, specify: ____

Child had a hearing test? Yes Results: ____

Child have a history of frequent ear infections? Yes If yes, how many/often: ____________________________

Tubes placed in ears? Yes If yes, date(s): ____

Child had a vision test? Yes Results: ____

Medications currently taking: ☐**NONE** or ____

Allergies (food/latex/tape/meds): ☐**NONE** or ____

Complications with pregnancy? ☐**NONE** or ____

Delivery: ☐C-Section ☐Vaginal ☐Forceps ☐Breech **Complications?** ☐NONE or ____________________

____

Birth Weight: ___ lb ___oz Premature? Yes If premature, how many weeks? ____________________

Concerns at birth? NICU? ☐**NONE** or ____

____

★★

Please describe your concerns/child's difficulties: ______________________________

____

What are your and/or your child's goals for therapy? ______________________________

____

____

Does your child have or complain of pain? Yes If yes, where and when? ____________________

____

Previous illnesses/hospitalizations (date): ☐**NONE** or ______________________________

____

Surgery (type & date): ☐**NONE** or ____

____

Testing (X-rays/MRI/CT; date & results): ☐**NONE** or ______________________________

____

Diagnosis (ADHD/Autism/CP): ☐**NONE** or ______________________________________

____

Previous and current therapy (please list timeframes and location including school services): ☐**NONE** or

- Physical: ____
- Occupational: ____
- Speech: ____

Child attend pre-school or school? Yes If yes, name: ___________________________________

Child have any eating problems? Yes List: ____

____

Child have any sleeping problems? Yes List: ____

____

Child ever stop talking or stop saying words s/he used to say? Yes If yes, describe: ______________

____

What is the primary way your child communicates? ☐Not applicable ☐1 word ☐2 words ☐gestures ☐3 or more word sentences ☐signs ☐communication device/pictures ☐Other: ______________

*Please give the **approximate ages** for the development of the following skills or check Not Applicable (N/A):*

Skill	Age	N/A		Skill	Age	N/A
Sitting		☐		Babbling		☐
Crawling		☐		1st words		☐
Walking		☐		Combined 2 words		☐
Self-feeding		☐		Produced sentences		☐
Self-dressing		☐		Bladder/Bowel Control		☐

Additional information you would like the therapist to know about your child: ____________________

____

____

____

____

FINANCIAL RESPONSIBILITY: Please bring your child's insurance card(s) to the evaluation visit.

Individual responsible for payment: _____ Relationship to Client: _____

Employer: _____ Phone: _____

Address: ☐ Same or _____

Primary Insurance Carrier: _____

Provider Phone # (back of card): _____ Member ID #: _____

Primary Insured Name: _____ Relationship to Client: _____

Social Security #: _____ Date of Birth: _____

Secondary Insurance Carrier ☐ N/A or _____

Provider Phone #(back of card): _____ Member ID #: _____

Primary Insured Name: _____ Relationship to Client: _____

Social Security #: _____ Date of Birth: _____

Community-STARs (C-STARs) will file insurance claims as a service to our clients.

- **You will be responsible for all deductibles, co-insurance and/or co-pays required by your plan.**
- We will verify your insurance eligibility prior to the evaluation. We strongly encourage you to call the member services number on your insurance card to understand your outpatient therapy benefits. You are their customer, not C-STARs. Please utilize the ***How to Determine Your Insurance Benefits*** document on our website.
- Having therapy visits in your insurance plan and receiving services from an in-network provider does not guarantee insurance coverage and reimbursement.
- Different insurance plans within each insurance company have different benefit limitations and exclusions which is why it is critical to determine your child's exact benefits.
- Many plans have therapy coverage with strict exclusions including, but not limited to, developmental delays or may require services to be deemed medically necessary on a case by case basis.
- C-STARs will bill your insurance company and accept payment directly from them.
- If rendered services are denied by your insurance company for any reason, you are responsible for payment to C-STARs for all rendered services provided. C-STARs will appeal the insurance denial on your behalf and work with you to facilitate insurance reimbursement.
- If you wish to continue services after an insurance denial has been received, you may continue as a private pay client until the insurance denial has been overturned. C-STARs requires this request to continue to be in writing with your signature and that of your child's therapist.

As the patient's legal representative your signature below certifies that:

* I am financially responsible for the cost of all non-covered, unauthorized, or services deemed to be not medically necessary by my child's insurance company.
* A quote of benefits from my child's insurance company is not a guarantee of payment. In the event the insurance chooses not to pay for any or all rendered services provided by C-STARs, I am ultimately responsible for all charges.
* I authorize the release of all medical and additional information necessary to process all insurance claims. I also authorize payment of insurance benefits/reimbursement to Community-STARs for billed services.

Signature of Parent/Guardian _____ **Date** _____

By typing in your name above this represents your legal signature on this document.

Bathroom Policy & Release I hereby authorize C-STARs to (check all that apply):

- ☐ Allow my child to go the bathroom unattended; my child is independent with toileting needs
- ☐ Allow my child to be accompanied to the bathroom while my child independently cares for toileting needs.
- ☐ Notify me when my child needs to go to the bathroom and I will be responsible for accompanying him/her; I will be available throughout the session.
- ☐ Notify me when my child needs a diaper change and I will be responsible to change my child; I will be available throughout the session (C-STARs will not be responsible for the diapering needs of your child).

Initial _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The privacy of your protected health information is important to us. A copy of our ***Notice of Privacy Practices*** is available at the clinic and on the C-STARs website. It describes how your health information will be handled.

Please include your email address here if you would like information emailed to you, including reports, home programs, etc. By providing your email address here you acknowledge that you understand that email is NOT considered a secure form of communication and you waive HIPPA privacy rules regarding email communication: _____

By signing below, I acknowledge that I have received C-STARs' Notice of Privacy Practices:

Signature of Parent/Guardian _____ **Date** _____

By typing in your name above this represents your legal signature on this document.

ATTENDANCE POLICY

14115 Lovers Lane Suite 115
Culpeper, VA 22701
Phone: (540)225-1150
Fax: (540)595-3482

Community-STARs is committed to providing all of our clients with exceptional and consistent care! We believe that **your commitment to your child's therapy schedule is essential** to their progress and ultimate development. We thank you in advance for your cooperation and attention to our attendance policy. Helping your child to reach their maximum potential and making everyday differences in their lives is our privilege!

Cancellations, Late Cancellations, and No Shows compromise your child's progress and prevent another child from receiving services that day.

Please call the office at 540-225-1150 by 3:00 p.m. on the day before your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 3:00 p.m. on Friday.

- **Late Cancellation**: Cancelling after 3pm the day before the appointment - you will be charged a $30 fee, not covered by your insurance
- **No Show**: Appointments missed without notification - you will be charged a $30 fee, not covered by your insurance
- After TWO **No Shows**, services for your child will be discontinued. Of course, special emergency circumstances will be considered.

* If your child has a fever within 24 hours of their session or you feel they are contagious, we ask that you notify us as soon as possible and reschedule the session when child is feeling better.

Flex Schedule

The Flex Schedule allows more flexibility for families when regular appointment days/times are challenging (schedules change week to week, medical appointments, or other circumstances). When on the Flex Schedule, there is no guarantee of availability of one particular therapist, specific time or day. Please let us know if the Flex Schedule works better for your family.

Your child will be switched to a "Flex Schedule" for the following reasons:

- **Late Cancellations:** More than 3 appointments per 3 months cancelled after 3pm the day prior to child's appointment.
- **Chronic cancellations**: attendance at less than 80% of scheduled appointments

In these cases, Community-STARs reserves the right to discontinue services.

Additional attendance policies:

- *Any changes to a client's physical status (recent extended hospitalization, surgery, etc) – a new prescription for services should be obtained*
- *Absences of 4 weeks or greater – a new prescription will need to be obtained*
- *Any misses or traveling of 3 weeks or more – client's appointment day/time will not be held*

By signing I certify that I have reviewed and agree to comply to C-STARs Attendance Policy.

Printed Name: _____ Relationship to child: _____

Signature: _____ Date:_____

By typing in your name above this represents your legal signature on this document.

Community
-STARs
Pediatric Therapy Specialists
*Physical *Occupational *Speech
14115 Lovers Lane, Suite 115
Culpeper, VA 22701
ph: 540-225-1150
fax: 540-595-3482

Thank you for your trust in our practice! As with the transmission of any communicable illness like a cold or the flu, you may be exposed to COVID-19, also known as Coronavirus, at any time or in any place. Rest assured that we have and will always follow the guidelines as set forth by the Culpeper Health Department as well as the CDC. We will use the recommended universal personal protection and disinfection protocols to limit transmission of all illnesses in our office.

Despite our careful attention to disinfection and use of personal barriers, there is still a chance that you and your child could be exposed to an illness in our office, just as you might at your gym, grocery store, or favorite restaurant. “Social Distancing” nationwide has reduced the transmission of COVID-19 (Coronavirus). Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the client, parent, therapist, staff, and sometimes other clients at all times.

☐ **I understand that Community-STARs reserves the right to reschedule any therapy appointment to a later date should you or your child exhibit any characteristics of illness including but not limited to runny nose, cough, fever, shortness of breath, etc.**

Although exposure is unlikely, do you accept the risk and consent to treatment? ☐ **Yes** ☐ **No**

Client Name _____ Client DOB _____

Parent/Guardian Name _____ Relation _____

Parent/Guardian Signature _____ Date _____

By typing in your name above this represents your legal signature on this document.

Please inform our office immediately if you would like to change your responses to this document.

Community
-STARs
Pediatric Therapy Specialists

14115 Lovers Lane Suite #115
Culpeper, VA 22701
Phone: 540-225-1150
Fax: 540-595-3482
CSTARs4Therapy@gmail.com

PHOTO/VIDEO RELEASE FORM

PERMISSION TO USE: ☐ PHOTOGRAPH(S) ☐ VIDEO(S)

I grant to School-based Therapy and Resources, LLC (STARs), Community-STARs (C-STARs), its representatives, and employees (referred to as STARs for rest of document) the right to take photographs and/or videos of my child in connection with therapy sessions. I authorize STARs to use and publish these photographs and/or videos; as well as any photographs and/or videos I provide to STARs in print and/or electronically.

☐ I understand that STARs **MAY USE** such photographs and/or videos of my child, without his/her name for any lawful purpose, including publicity, illustration, advertising, social media, and website content.

OR

☐ I would like to **OPT OUT** of STARs posting photographs and/or videos of my child, without his/her name on: (Check all that apply)

- ☐ C-STARs clinic walls
- ☐ STARs website
- ☐ Social Media (Facebook, Instagram)
- ☐ Marketing materials

If at any point I wish to revoke my permission, I can do so in writing directly to STARs. I have read and understand the above.

_____ _____
Client Name Client DOB

_____ _____
Parent/Guardian Name Relation

_____ _____
Parent/Guardian Signature Date

By typing in your name above this represents your legal signature on this document.